* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Heart Attack / Cardiomyopathy / Pericardial Disease / Cardiac Arrhythmia / Angioplasty and Other Invasive Treatment for Coronary Artery / Coronary Artery By-Pass Surgery / Other Serious Coronary Artery Disease

SECTION 2 – DOCTOR'S STATEMENT (to be completed by the attending doctor at claimant's expense)

A) Patient's Particulars

Name of Patient	Gender

NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy)

B) Patient's Medical Records

1) Please state over what period does the Hospital/Clinic's record extend?

(i) Date of **First** Consultation (ddmmyyyy)

(ii) Date of **Last** Consultation (ddmmyyyy)

(iii) Number of consultations during the above period:

(iv) Name of hospital/clinic and Reasons for consultations (with dates):

2) Are you the patient's usual medical doctor? ❒ Yes ❒ No

If "Yes", since when? (ddmmyyyy)

If "No", please provide name and address of the patient's regular doctor.

3) Was the patient referred to you? ❒ Yes ❒ No

If "Yes", please provide:

(i) Date referred (ddmmyyyy)

(ii) Reason the patient was referred:

(iii) Name and address of doctor recommending the referral:

If "No", how did the patient come to consult at your hospital/clinic? (e.g. A&E.)

4) Have you referred the patient to any other doctor? ❒ Yes ❒ No

(i) Date referred (ddmmyyyy)

(ii) Reason for referral:

(iii) Name and address of doctor referred to:

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5) Does the patient have or ever have had any significant health conditions, medical history or any illness (e.g. hyperlipidaemia, hypertension, angina, hepatitis, diabetes, tumour, etc.)? If "Yes", please provide: ❒ Yes ❒ No

Details of symptoms	Exact diagnosis	Date diagnosed	Treatment

6) Name and address of doctor whom the patient consulted for the condition(s) stated in Question 5 above.

7) What is your source of the above information?

8) Please give details of the patient's habits in relation to past and present **smoking**, including the duration of smoking habits, number of cigarettes smoked per day and source of this information:

No. of years of smoking	No. of sticks per day	Source of information

9) Please give details of the patient's habits in relation to **alcohol consumption**, including the amount of the alcohol consumption, frequency and the source of this information.

Type of alcohol	Quantity per Consumption	Frequency (per week / month, etc)	Source of information

C) Details of Illness

1) Please provide details of condition:

(i) Date of **First** consultation for this condition (ddmmyyyy) | | | | | | | | |

(ii) Details of symptom(s) presented at **First** consultation

(iii) Date of onset of these symptoms (ddmmyyyy) | | | | | | | | |

(iv) What is the underlying cause(s) of the symptoms?

(v) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

(vi) Date of **First** diagnosis (ddmmyyyy) | | | | | | | | |

(vii) Date the patient **First** became aware of the illness/condition (ddmmyyyy) | | | | | | | | |

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2) Please provide dates and details of investigation performed for the diagnosis and attach a copy of all relevant test reports which confirmed the diagnosis.

3) Name and address of the doctor / cardiologist who **First** diagnosed the patient with this condition.

4) Has the patient previously suffered from a Heart Attack or any related illnesses (e.g. hypertension, angina or other vascular disease? If "Yes", please provide details: ❒ Yes ❒ No

Date of **First** diagnosis	Exact diagnosis	Name of doctor and Address of hospital/clinic

5) Has the patient suffered from **Heart Attack**? ❒ Yes ❒ No

If "No", please proceed to **Question 6**.

If "Yes", please advise:

(i) Nature of episode:

(ii) Date of initial episode (ddmmyyyy)

(iii) Duration of acute symptoms:

(iv) Was there a current history of typical chest pain? ❒ Yes ❒ No

(v) Were there any changes in the ECG indicative of new myocardial infarct? ❒ Yes ❒ No

If "Yes", please state whether there was any:

		Date of Test (DD/MM/YYYY)
(a) ST elevation or depression?	❒ Yes ❒ No	
(b) T wave inversion?	❒ Yes ❒ No	
(c) Pathological Q waves?	❒ Yes ❒ No	
(d) Left bundle branch block?	❒ Yes ❒ No	

Please **attach** a copy of the ECG tracing report.

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(vi) Was there a diagnostic elevation of cardiac biomarkers, such as CKMB, Troponin T or I, etc.? ❒ Yes ❒ No

If "Yes", please provide type, date and time of test, and test results:

Type of Cardiac Biomarker	**Date of Test (*before* any cardiac procedure)**	**Time of Test (*before* any cardiac procedure)**	**Test Results (specify the units)**
CKMB			
Troponin T or I (ng/ml or ug/L or pg/ml)			
Other Cardiac Biomarker If "Yes", please state:			

Type of Cardiac Biomarker	**Date of Test (*after* any cardiac procedure)**	**Time of Test (*after* any cardiac procedure)**	**Test Results (specify the units)**
CKMB			
Troponin T or I (ng/ml or ug/L or pg/ml)			
Other Cardiac Biomarker If "Yes", please state:			

Please **attach** a copy of the laboratory results.

If "**No**", please provide us the reason for not performing the cardiac biomarkers tests**.**

(vii) Please advise with regard to the left ventricular ejection fraction:

(a) Was there left ventricular ejection fraction of less than 50% measured three months or more after the event? ❒ Yes ❒ No

(b) What was the left ventricular ejection fraction at initial diagnosis? ❒ Yes ❒ No

(viii) Was there death of a portion of the heart muscle? ❒ Yes ❒ No

If "Yes", please provide details:

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(ix) Was there imaging evidence of

(a) new loss of viable myocardium ❒ Yes ❒ No

(b) new regional wall motion abnormality? ❒ Yes ❒ No

If "Yes", please elaborate with supporting evidence of imaging reports and name of the attending cardiologist.

(c) Please provide details of the surgery and/or other mode of treatment that had been performed, including name and date of treatment, and name and address of attending cardiologist.

(d) Date of return to normal activities (ddmmyyyy): | | | | | | | | |

6) Has the patient suffered from **Cardiomyopathy**? ❒ Yes ❒ No

If "No", please proceed to **Question 7**.

If "Yes", please advise:

(i) Date of **First** diagnosis of Cardiomyopathy (ddmmyyyy) | | | | | | | | |

(ii) Has the patient previously undergone any cardiac investigation (e.g. ECG, echocardiogram, CT scan, etc.)? ❒ Yes ❒ No

If "Yes", please advise:

(a) Type of cardiac investigation done:

(b) Date of investigation (ddmmyyyy) | | | | | | | | |

Please **attach** a copy of the above investigation reports.

(iii) Was the diagnosis of Cardiomyopathy made unequivocally by cardiac echographic findings of compromised ventricular performance? ❒ Yes ❒ No

If "Yes", please attach a copy of the echographic findings report.

If "No", please specify the basis of diagnosis.

(iv) Does the patient have any cardiac or physical impairment which fulfills the New York Heart Association (NYHA) Classification of Cardiac Impairment criteria? ❒ Yes ❒ No

If "Yes", please describe the patient's current symptoms.

Please state the NYHA class of impairment? (delete as appropriate): **Class I / II / III / IV**

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(v) Has the Cardiomyopathy resulted in permanent physical impairments of at least Class III of the New York Heart Association (NYHA) Classification of Cardiac Impairment? ❒ Yes ❒ No

If "Yes", please circle the patient's NHYA Classification for the current condition and provide us with the full details in the table below:

NYHA Classification ***Please circle**	**What is the limitation in physical activity that patient has?**	**Is the limitation of physical activity permanent?** ***Please circle**
Class I: (No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, or anginal pain)		Yes / No
Class II: (Slight limitation of physical activity. Ordinary physical activity results in Symptoms)		Yes / No
Class III: (Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms)		Yes / No
Class IV: (Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest)		Yes / No

(vi) What was the underlying cause of the Cardiomyopathy?

(vii) Is the patient's Cardiomyopathy related to:

(a) Alcohol misuse? ❒ Yes ❒ No

(b) Drug misuse? ❒ Yes ❒ No

If "Yes", please provide details of alcohol/drug consumption, including the amount, frequency and types of consumption.

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7) Has the patient suffered from **Pericardial disease**? ❒ Yes ❒ No

If "No", please proceed to **Question 8**.

If "Yes", please advise the following:

(i) Date of **First** diagnosis of Pericardial disease (ddmmyyyy)

(ii) Was surgery performed for the patient's pericardial disease condition? ❒ Yes ❒ No

If "Yes", please advise:

(a) Type of surgery performed (e.g. pericardectomy, keyhole cardiac surgery, etc.):

(b) Date of surgery (ddmmyyyy):

(c) Time of surgery (hh:mm):

Please **attach** a copy of the above investigation reports.

(iii) Was the surgery performed considered medically necessary by the consultant cardiologist? ❒ Yes ❒ No

(iv) Was there any other mode of treatment other than the above surgery that could have been performed? ❒ Yes ❒ No

If "Yes", please specify:

(a) Alternate mode of treatment.

(a) Reasons why the above alternate mode of treatment was not used.

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8) Has the patient suffered from **Cardiac Arrhythmia**? ❒ Yes ❒ No

If "No", please proceed to **Section 9**.

If "Yes", please advise:

(i) Type of cardiac arrhythmia presented:

(ii) Date of **First** diagnosis (ddmmyyyy) | | | | | | | | |

(iii) Was pathway ablation therapy attempted? ❒ Yes ❒ No

If "Yes", please state the date of therapy (ddmmyyyy) | | | | | | | | |

If "No", why was this not done?

(iv) Was a permanent cardiac pacemaker inserted? ❒ Yes ❒ No

If "Yes", please state the date of insertion (ddmmyyyy) | | | | | | | | |

(v) Was a permanent cardiac defibrillator inserted? ❒ Yes ❒ No

If "Yes", please state the date of insertion (ddmmyyyy) | | | | | | | | |

(vi) Was there any other mode of treatment which could have been used to treat the patient's cardiac arrhythmia? If "Yes", please specify: ❒ Yes ❒ No

(a) Alternate mode of treatment.

(b) Reasons why the above alternate mode of treatment was not used.

Please **attach** a copy of the ECG tracing.

9) Has the heart disease that led to **Coronary Angioplasty or similar intra-arterial catheter procedure**? ❒ Yes ❒ No

If "No", please proceed to **Section 10**.

If "Yes", please advise:

(i) Please state type of procedure performed.

(ii) a) Date the procedure was performed (ddmmyyyy): | | | | | | | | |

b) Time of procedure performed (hh:mm): | | | | | |

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(iii) Please specify the coronary arteries involved and the degree (%) of narrowing, and **attach** a copy of **Angiogram report**.

Coronary Artery	Stenosis	Percentage of Stenosis
Left Main Stem	❒ Yes ❒ No	
Left Anterior Descending Artery	❒ Yes ❒ No	
Left Circumflex Artery	❒ Yes ❒ No	
Right Coronary Artery	❒ Yes ❒ No	

(iv) Name of surgeon who performed the procedure and name of hospital in which it was performed.

(v) Please provide full details of any other treatment provided.

(vi) Was the procedure considered medically necessary by the consultant cardiologist? ❒ Yes ❒ No

(vii) Has the patient undergone a similar procedure before? ❒ Yes ❒ No

If "Yes", please state date and place where it was performed, and the reason(s) for the procedure.

(viii) Did the patient previously suffer from coronary artery disease or any related illness? ❒ Yes ❒ No

If "Yes", please provide details including date of diagnosis, exact diagnosis, treatment prescribed, and name and address of attending doctor.

(ix) Have any other investigative tests or procedure been performed? ❒ Yes ❒ No

If "Yes", please provide details and attach a copy of results (e.g. angioplasty operation report, myocardial perfusion test, 2-D echocardiogram, etc).

10) Has the heart disease that led to **Surgery or Serious Coronary Artery Disease**? ❒ Yes ❒ No

If "No", please proceed to **Section D**.

If "Yes", please advise:

(i) Name and address of the **cardiologist** who **First** diagnosed the patient with this condition.

(ii) Please tick (√) the type of surgery performed:

❒ Coronary Artery Bypass Surgery ❒ Transmyocardial Laser Revascularization

❒ "Keyhole" Surgery ❒ Atherectomy

❒ Enhanced External Counterpulsation ❒ Others (please specify):

(iii) a) Date the surgery was performed (ddmmyyyy):

b) Time of procedure performed (hh:mm):

(iv) Please specify the coronary arteries involved and the degree (%) of narrowing, and **attach** a copy of **Angiogram report**.

Coronary Artery	Stenosis	Percentage of Stenosis
Left Main Stem	❒ Yes ❒ No	
Left Anterior Descending Artery	❒ Yes ❒ No	
Left Circumflex Artery	❒ Yes ❒ No	
Right Coronary Artery	❒ Yes ❒ No	

(v) If an open chest (open heart) surgery was performed, please state:

(a) Number of grafts:

(b) Sites of grafts inserted:

(vi) Name of surgeon(s) who performed the surgery and name of hospital in which surgery was performed.

(vii) Please provide full details of any other treatment provided.

(viii) Was the above surgery considered medically necessary by the consultant cardiologist? ❒ Yes ❒ No

(ix) Has the patient undergone a similar surgery before? ❒ Yes ❒ No

If "Yes", please provide details, including date and place of surgery, and the reasons for the surgery.

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(x) Did the patient previously suffer from coronary artery disease or any related illness? ❒ Yes ❒ No

If "Yes", please provide details including date of diagnosis, exact diagnosis, treatment prescribed, and name and address of attending doctor.

(xi) Have any other investigative tests or procedure been performed? ❒ Yes ❒ No

If "Yes", please provide details and attach a copy of the results (e.g. cardiac catheterization report, myocardial perfusion test, etc.).

D) Other Information

1) What is the prognosis of the patient's condition?

2) Is the patient still on follow-up? ❒ Yes ❒ No

If "Yes", please state date of next appointment (ddmmyyyy):

If "No", please state date of discharge (ddmmyyyy):

3) Has the patient **previously** had any cardiac investigation done (e.g. ECG, echocardiogram, CT scan)? ❒ Yes ❒ No

If "Yes", please provide details:

(i) Type, results and date of cardiac investigation done:

(ii) Reasons for the investigation:

(ii) Name of cardiologist and address of hospital / clinic:

4) Is there anything in the patient's **personal medical history** which would have increased the risk of heart diseases? ❒ Yes ❒ No

If "Yes", please provide details:

Exact diagnosis | Date of diagnosis | Name of doctor & address of hospital/clinic

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5) Is there anything in the patient's **family history** which would have increased the risk of Heart disease? ❒ Yes ❒ No

If "Yes", please give details:

Relationship with patient	Nature of condition	Age of onset	Source of information

6) a) Is the patient mentally incapacitated? ❒ Yes ❒ No

b) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? ❒ Yes ❒ No

7) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the condition? ❒ Yes ❒ No

If "Yes", please give details:

8) Is the patient's diagnosis or surgery directly or indirectly, wholly or partly caused by or arising from or contributed to by:

i) Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? ❒ Yes ❒ No

If "Yes", please provide details:

Date of Diagnosis of AIDS/HIV (dd/mm/yyyy): | | | | | | | | |

Date the patient **First** became aware of the condition: (ddmmyyyy): | | | | | | | | |

ii) wilful misuse of drugs? ❒ Yes ❒ No

iii) wilful misuse of alcohol? ❒ Yes ❒ No

iv) congenital anomaly or defect? ❒ Yes ❒ No

If "Yes" for any of the above, please provide the details including diagnosis date, name of doctor and clinic who **First** diagnosed the patient with HIV or AIDS, wilful misuse of drugs, wilful misuse of alcohol or congenital anomaly or defect. Please provide copy of test result.

9) Please provide us with any other additional information that will enable the Company to assess this claim.

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10) Please enclose a copy of all investigations reports including specialist or hospital reports, cardiac enzyme assays, exercise stress tests, coronary angiography, echocardiography, myocardial perfusion scans and referral letter (if any).

E) Declaration	
I hereby declare that the above answers are true to the best of my knowledge and belief.	
Signature of Doctor	Address & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	

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